DSS-CP-536-06/89

BACKGROUND INFORMATION

Must be typed to be microfilmed.
To be completed with biological parent.

Child(ren) _____

Mother ☐ **Father** ☐

IDENTIFYING INFORMATION

Your Name _____ **Phone** _____

Address _____
(Street, City, State, Zip)

Birth Date _____ **Birth Place** _____

Child's Grandparent's Name _____

Phone _____

Address _____
(Street, City, State, Zip)

Religion _____

Race/Nationality: _____

If Native American (Indian), give Tribe, where you are enrolled, and enrollment #:

_____

Marital Status: Single ☐ Married ☐ Divorced ☐

Date and Place of Marriage _____

Date and Place of Divorce _____

Spouse's Name _____ **Phone** _____

Address _____
(Street, City, State, Zip)

If spouse is dead, give date and cause of death. _____

DESCRIPTION

Height _____ **Eye Color** _____ **Usual Weight** _____

Skin Color _____ **Birth Mark** Yes ☐ No ☐

Hair Color and Texture _____

Distinguishing physical features _____

Describe your personality _____

EDUCATION

Last grade completed _____ **Presently in School?** Yes ☐ No ☐

What are your feelings about school? _____

Extracurricular Activities: _____

Subjects Interested In: _____

Talents, Hobbies, Interests: _____

EMPLOYMENT HISTORY

Current Job: _____

Length of time employed: _____ **Military Service:** _____

Previous Jobs: _____

YOUR PERSONAL HEALTH

General Health _____

Childhood Diseases _____

Major Surgery-For what condition? _____ **When?** _____

Allergies _____

Glasses: Yes ☐ No ☐ **For what condition?**

Astigmatism _____
Far sighted _____
Near sighted _____
Strabismus (cross-eyed) _____
Other _____
Specify _____

DRUG USAGE

1. **Alcohol:** Yes ☐ No ☐ How often _____ Amount _____
2. **Cigarettes:** Yes ☐ No ☐ How often _____ Amount _____
3. **Marijuana:** Yes ☐ No ☐ How often _____ Amount _____
4. **Cocaine:** Yes ☐ No ☐ How often _____ Amount _____
5. **Amphetamines (Uppers):** Yes ☐ No ☐ How often _____ Amount _____
6. **Barbiturates (Downers):** Yes ☐ No ☐ How often _____ Amount _____
7. **Other (Specify):**
   - **a.** Yes ☐ No ☐ How often _____ Amount _____
   - **b.** Yes ☐ No ☐ How often _____ Amount _____

FAMILY HISTORY

Were you or any member of your immediate family adopted? Yes ☐ No ☐

If yes, please tell who _____

	Your Natural Father	Your Natural Mother
Name		
Address		
Birthdate or age		
If Deceased, Age at Death		
Cause of Death		
Height		
Weight		
Hair Color and Texture		
Eye Color		
Skin Color		
Outstanding Features		
Education Completed		
Racial Background		
Ethnic Background		
Religion		
Marital Status		
Aware of Pregnancy?	Yes ☐ No ☐	Yes ☐ No ☐
Give names of aunts & uncles and General physical appearance		
If any of them have died, give age at death & cause		

Your Father's Parents

	Father	Mother
Name		
Address		
Age		
Describe physical appearance		
Height		
Weight		
Outstanding Features		
Current or former occupation		
If deceased, age at death and cause		
Aware of Pregnancy?	Yes ☐ No ☐	Yes ☐ No ☐

Your Mother's Parents

	Father	Mother
Name		
Address		
Age		
Describe physical appearance		
Height		
Weight		
Outstanding Features		
Current or former occupation		
If deceased, age at death and cause		
Aware of Pregnancy?	Yes ☐ No ☐	Yes ☐ No ☐

Your Brothers and Sisters

Name			
Birthdate or Age			
If deceased, age at death and cause			
Height			
Weight			
Hair color and texture			
Eye color			
Skin color			
Hobbies and talents			
Last grade completed			
Presently in school?			
Name of school			
Occupation			
Aware of pregnancy?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Marital Status			
Number of children they have			
Health of their children			

Your Brothers and Sisters

Name			
Birthdate or Age			
If deceased, age at death and cause			
Height			
Weight			
Hair color and texture			
Eye color			
Skin color			
Hobbies and talents			
Last grade completed			
Presently in school?			
Name of school			
Occupation			
Aware of pregnancy?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Marital Status			
Number of children they have			
Health of their children			

Your Children

Name			
Birthdate or Age			
If deceased, age at death			
Cause of death			
Racial background			
Height			
Weight			
Hair color and texture			
Eye color			
Skin color			
Grade in school			
Present Whereabouts			
Hobbies and talents			
General Health			
Major surgery			
Health problems			
Aware of pregnancy?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Your Children

Name			
Birthdate or Age			
If deceased, age at death			
Cause of death			
Racial background			
Height			
Weight			
Hair color and texture			
Eye color			
Skin color			
Grade in school			
Present Whereabouts			
Hobbies and talents			
General Health			
Major surgery			
Health problems			
Aware of pregnancy?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

MEDICAL HISTORY

Please indicate by checking "yes" or "no" if YOU or any Natural Relatives (i.e. your mother, or father, sisters, brothers, grandparents, aunts, uncles or any other children you have had) ever had or now have the medical items listed. Also complete the comment section, including information pertaining to parts of the body involved, age at onset, frequency, treatment or medication, hospitalization, diagnosis or cause, etc. when applicable.

Medical Condition	**You**		**Other Relatives**			
	No	**Yes**	**No**	**Yes**	**Who** (mother/father,etc.)	**Comments**
Birth Defects Club Foot	☐	☐	☐	☐		
Harelip (cleft lip or cleft palate)	☐	☐	☐	☐		
Congenital heart disease	☐	☐	☐	☐		
Any other malformation	☐	☐	☐	☐		
Muscular Diseases Muscular Dystrophy	☐	☐	☐	☐		
Multiple Sclerosis	☐	☐	☐	☐		
Cerebral Palsy	☐	☐	☐	☐		
Other Paralysis or crippling disorder	☐	☐	☐	☐		
Neurological Disorders Seizures, convulsions, or epilepsy	☐	☐	☐	☐		
Other neurological problems	☐	☐	☐	☐		
Handicaps or Disabilities Blindness or serious trouble seeing	☐	☐	☐	☐		
Deafness or serious trouble hearing	☐	☐	☐	☐		
Speech Problem	☐	☐	☐	☐		
Learning Disability (Special Education?)	☐	☐	☐	☐		
Mental Retardation	☐	☐	☐	☐		

Medical Condition	You		Other Relatives			
	No	**Yes**	**No**	**Yes**	**Who** (mother/father,etc.)	**Comments**
Hormone Disorders Diabetes	☐	☐	☐	☐		
Hypoglycemia	☐	☐	☐	☐		
Thyroid disorder	☐	☐	☐	☐		
Other hormone disorders	☐	☐	☐	☐		
Respiratory Problems Emphysema	☐	☐	☐	☐		
Asthma	☐	☐	☐	☐		
Hay fever or other allergy	☐	☐	☐	☐		
Blood Diseases Hemophilia	☐	☐	☐	☐		
Sickle cell anemia (carrier or disease?)	☐	☐	☐	☐		
Heart Problems High blood pressure	☐	☐	☐	☐		
Stroke	☐	☐	☐	☐		
Heart attack (Coronary)	☐	☐	☐	☐		
Other cardiovascular problems	☐	☐	☐	☐		
Other Diseases or Illnesses Cancer	☐	☐	☐	☐		
Tumors	☐	☐	☐	☐		
Cystic fibrosis	☐	☐	☐	☐		
Huntington's disease	☐	☐	☐	☐		
Parkinson's disease	☐	☐	☐	☐		
Emotional or mental illness	☐	☐	☐	☐		
Any other condition that runs in your family?	☐	☐	☐	☐		

For Genetic Mother Only

Menstrual and Pregnancy History

Name: _____

Onset of Menses (Age): _____ **Cramps?** _____

Usual Length of Period: _____ **Regular?** _____

No. of Days Between _____

Have you had previous pregnancies? Yes ☐ No ☐

Please List All Your Pregnancies In Order. Use one line for each child or for each miscarriage, therapeutic abortion, or stillbirth.

Name of child (or write baby boy, baby girl, miscarriage, therapeutic abortion, or stillborn)	How Many Months did you carry this pregnancy?	Year in which pregnancy ended	If Miscarriage or Therapeutic Abortion, was it natural or induced